HARTFORD HOSPITAL TRANSPLANT PROGRAM
Kidney Donor History and Health Questionnaire

Please answer the following questions to the best of your knowledge. If you are not sure, please leave those questions blank and complete the rest. We will help you fill in the remaining at the interview.

Name: ________________________________ Date of birth: ________________ Today's date: ____________
Recipient Name: __________________________________ Your relationship to recipient: ____________________
Primary Care Physician: ________________________________ City ________________________________
Have you had a physical within the last 12 months? ☐No ☐Yes (If not, you will be required to have one)
Current Medical Insurance ☐No ☐Yes Name of insurance: ____
Are you being pressured or forced into donating your kidney? ☐No ☐Yes If YES, Please explain. ____________
____
Are you being offered any compensation for donating your kidney? ☐No ☐Yes If YES, please explain. __________
____
Is your spouse/significant other aware of your decision to donate a kidney? ☐No ☐Yes
Is your employer willing to give you time off for the evaluation and recovery after donating? ☐No ☐Yes
Do you have any concerns about the recipient's commitment to taking care of the transplanted kidney? ☐No ☐Yes

MEDICAL HISTORY: (Include description and year)	**SURGICAL HISTORY:** (Include description and year)
Height:	None:
Weight: Weight at birth:	Heart surgery:
Diabetes: Gestational Diabetes:	Carotid surgery:
Hypertension/High Blood Pressure:	Gall Bladder / Appendectomy
Cancer:	Tonsillectomy:
Heart disease:	Prostate surgery:
Lupus:	Other urologic surgery:
Stroke:	Amputation:
Chronic infections (TB etc)	C-Section / Hysterectomy:
Gout:	Breast biopsy:
Deep vein thrombosis (DVT)/Blood Clot:	Other biopsey:
Seizures:	Any complications from anesthesia?
Hepatitis / liver disease /jaundice:	What is your blood type?☐ A ☐ B ☐ AB ☐ O ☐ unknown
HIV / AIDS:	
Other:	

MEDICATIONS: (Please indicate dose and frequency) ____
____
Please list any **allergies** to medications and what reaction they cause: ______________________________
____
What is your current employment: ____
How long have you worked at your present job: ____
Are you not working due to disability? ☐No ☐Yes is so when did you become disabled? ______________
Are you married? ☐No ☐Yes For how many years? __________ Divorced? ☐No ☐Yes
Do you have children? ☐No ☐Yes If so, how many? ______________ Ages: ______________________
Do any of your children have significant health problems? ☐No ☐Yes explain __________________________
Who would be available to help you around time of surgery ? ______________________________________
Use of alcohol: Never ______ Occasionally _______ Regularly ________ Previously, but quit _______
Use of tobacco: Never _______ Packs per day ______ Previously, but quit ______________________
Use of illegal drugs: Yes: ________ Never ________ Previously, but quit _____________________________
Ever been in a drug or alcohol rehabilitation program? ☐No ☐Yes explain ___________________________
Ever been under the care of a mental health professional? ☐No ☐Yes explain- ________ ______________
Any tattoos or body piercing ? ____
Ever been in jail? ☐No ☐Yes When? ______________ How long? __________

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FAMILY HISTORY (List which family members have the following?)

Liver Disease:	Hypertension:
Kidney Disease:	Heart Disease:
Diabetes:	Cancer:
Bleeding Disorder:	Stroke:

	Age	Health Problems/Cause of Death
Mother □ Alive □ Deceased		
Father □ Alive □ Deceased		
Number of Sisters Number of Brothers		

REVIEW OF SYSTEMS **Circle NO/YES**

GENERAL		**MUSCULOSKELETAL**	
Fever	□NO□YES	Joint Pain/Swelling	□NO□YES
Fatigue	□NO□YES	Muscle/Joint Weakness	□NO□YES
Insomnia	□NO□YES	Back Pain	□NO□YES
Stress	□NO□YES	Cold Extremities	□NO□YES
Chills /night sweats	□NO□YES	Numbness/Tingling in Arms or Legs	□NO□YES
EYES, EARS, NOSE, MOUTH, THROAT		Varicose Veins	□NO□YES
Eye/Vision Problems	□NO□YES	**BREAST**	
Hearing Loss/Ringing	□NO□YES	Breast Pain or Lump	□NO□YES
Earaches	□NO□YES	Nipple Discharge/Bleeding	□NO□YES
Nosebleeds	□NO□YES	Any lump in armpit	□NO□YES
Frequent Colds	□NO□YES	**NEUROLOGIC/PSYCHOLOGIC**	
Dental Problems	□NO□YES	Frequent Headaches	□NO□YES
Sore Throat/Hoarseness	□NO□YES	Lightheaded/Dizzy	□NO□YES
Swollen Glands	□NO□YES	Paralysis	□NO□YES
HEART AND LUNGS		Depression/ Psychiatric problems	□NO□YES
Chest Pain	□NO□YES	**ENDOCRINE**	
Irregular/Fast Heartbeat	□NO□YES	Osteoporosis/bone disease	□NO□YES
Shortness of Breath	□NO□YES	Excessive Thirst or Urination	□NO□YES
Swelling of Feet/Ankles	□NO□YES	Heat or Cold Intolerance	□NO□YES
Cough	□NO□YES	Thyroid problems	□NO□YES
Asthma/Wheezing	□NO□YES	**SKIN**	
Coughing up phlegm	□NO□YES	Rash/Itching	□NO□YES
Spitting up Blood	□NO□YES	Bleeding/Bruising	□NO□YES
GASTROINTESTINAL		Change in Skin/Hair/Nails Any tattoos / body piercing ?	□NO□YES
Abdominal Pain	□NO□YES	**PAST OR CURRENT INFECTIONS**	
Nausea/Vomiting	□NO□YES	Chicken pox	□NO□YES
Diarrhea	□NO□YES	Hepatitis A / B / C	□NO□YES
Constipation	□NO□YES	HIV	□NO□YES
Change in Bowels	□NO□YES	Herpes	□NO□YES
Hemorrhoids	□NO□YES	Tuberculosis	□NO□YES
Bleeding	□NO□YES	Other infections	□NO□YES
GENITOURINARY	□NO□YES	**MALES (ONLY)**	
Frequent Urination	□NO□YES	Pain or Swelling in Testicle	□NO□YES
Pain or Burning with Urination	□NO□YES	Prostate Problems	□NO□YES
Bladder Control Problems	□NO□YES	Erectile dysfunction	□NO□YES
Blood in Urine	□NO□YES	**FEMALES (ONLY)**	
Kidney Stones	□NO□YES	Severe Cramps or Irregular Menses	□NO□YES
Change in Force or Stream	□NO□YES	Heavy bleeding with menses Date of last Menstrual period ________________	□NO□YES
Decreased Daily Volume of Urine	□NO□YES	History of abnormal Pap Smear Date of last Pap Smear ________________	□NO□YES
Sexually Transmitted Disease	□NO□YES	History of abnormal Mammogram Date of last mammogram ________________	□NO□YES
BLEEDING DISORDERS	□NO□YES	How many Previous Pregnancies	
Slow to Heal after Cuts	□NO□YES	Diabetes in Pregnancy	□NO□YES
Anemia	□NO□YES	High Blood Pressure in Pregnancy	□NO□YES
Blood Clots or Phlebitis	□NO□YES	How many Full-Term Deliveries	
Any religious/ethical concerns regarding blood transfusions	□NO□YES	How many Miscarriages/Abortions	
Any bleeding problems	□NO□YES	Family History of Breast Cancer	□NO□YES
		Taking hormone replacement:	□NO□YES
		Birth control pills	□NO□YES